

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4714	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/05/2011
NAME OF PROVIDER OR SUPPLIER MERCY MEDICAL CENTER TRANSITIONAL CA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on January 6, 2011 no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
*Norma E. Kinsey*TITLE
Admin

(X6) DATE

1-24-11

STATE FORM

5809

9BSH21

If continuation sheet 1 of 1